



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

CONSULTANTS IN PAIN MEDICINE

Respondent Name

TRAVELERS INDEMNITY COMPANY OF AMERICA

MFDR Tracking Number

M4-18-0322-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

October 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...it seems that you denied code 80307. We feel this was denied in error... Should not be considered inclusive as one is a screening and the other a confirmation."

Amount in Dispute: \$98.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0483 reimbursed under this date of service. The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 21, 2017	80307	\$98.85	\$76.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - P12 – Workers’ compensation jurisdictional fee schedule fee schedule adjustment
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
 - W3 – Additional payment made on appeal/reconsideration
 - 151 – Payment adjusted because the payer deems the information submitted does not support his many services
 - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
 - 6578 – Individual laboratory codes which are part of a more comprehensive laboratory panel code were reimbursed at an all-inclusive panel code. All other drug screen codes are included in the reimbursement for the comprehensive laboratory code.

Issue(s)

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What rule is applicable to fee calculation?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 80307 rendered on June 21, 2017. The insurance carrier states in their position statement, “The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0483 reimbursed under this date of service.” The requestor states in pertinent part, “We feel this was denied in error... Should not be considered inclusive as one is a screening and the other a confirmation.”

Review of the National Correct Coding Initiative Procedure-to-Procedure (PTP) from the Centers for Medicare and Medicaid services at www.cms.gov found no edits exist between codes G0483 and 80307.

CPT Code 80307 is defined as “Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LCMS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.”

The NCCI Policy Manual, Chapter 10, Section E (Drug Testing) also at www.cms.gov states,

Beginning January 1, 2017, urine drug presumptive testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

Beginning January 1, 2016, urine drug definitive testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.

The Division finds that based on the above, the insurance carrier’s denial reasons are not supported. The service in dispute is therefore reviewed per applicable fee guidelines.

2. The service in dispute is subject to the provisions of 28 Texas Administrative Code 134.203 (e) which states in relevant part, The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:
 - (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,
 - (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

Review of the 2017 Clinical Diagnostic Laboratory Fee Schedule finds no separate reimbursement for the professional fee. The maximum allowable reimbursement calculation is Medicare Allowable x 125% or \$61.02 x 125% = \$76.28. Therefore, this amount is recommended.

3. The total allowable for the service in dispute is \$76.28. The carrier previously paid \$0.00. The requestor is due a payment of \$76.28.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$76.28

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$76.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

_____	_____	November 3, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.